July 2001

WEST VIRGINIA INFORMATIONAL LETTER

NO. 134

TO: ALL HEALTH MAINTENANCE ORGANIZATIONS LICENSED TO DO BUSINESS IN THE STATE OF WEST VIRGINIA

RE: PATIENT BILL OF RIGHTS

By Informational Letter 122, issued July, 2000, this office instructed all health maintenance organizations to provide notice of certain subscriber rights on a form set forth in the Informational Letter. The form, designated the "HMO Patient Bill of Rights," was required to be provided to all HMO subscribers pursuant to West Virginia Code Section 33-25C-3. During the 2001 legislative session, West Virginia Code Section 33-25C-3 was amended by House Bill 2216, enrolled and passed on April 14, 2001 and effective July 13, 2001. In order to comply with West Virginia Code Section 33-25C-3, as amended, managed care plans are now instructed to provide to subscribers the revised "HMO Patient Bill of Rights" set forth in this letter.

The amended notice of subscribers' rights must be printed in a commonly used font face and in no less than 10 point font size. This amended notice is to be provided to all HMO subscribers by July 1, 2002. The initial amended notice may be provided through individual mass mailing, may be incorporated in the subscriber handbook, or may be provided with the HMO newsletter. After July 1, 2002, the notice is to be provided to all new subscribers upon enrollment and to all existing subscribers upon contract renewal. Additionally, the notice is to be incorporated into each subscriber handbook by the next open enrollment period following July 1, 2002.

Any questions regarding the amended HMO Patient Bill of Rights should be directed to the Consumer Services Division, West Virginia Insurance Commission, P.O. Box 50540, Charleston, West Virginia 25305-0540, Phone: (304) 558-3386 or 1-800-642-9004.

Jane L. Cline Insurance Commissioner

HMO PATIENT BILL OF RIGHTS

- 1. You have the right to a description of your rights and responsibilities, plan benefits, benefit limitations, premiums, and individual cost-sharing requirements.
- 2. You have the right to a description of the HMO's grievance and hearing procedures and the right to pursue grievance and hearing procedures without reprisal from the Health Maintenance Organization (HMO).
- 3. You have the right to a description of the method in which you can obtain a list of the plan's provider network, including the names and credentials of all participating providers, and the method by which you may choose providers within the plan.
- 4. You have the right to choose an available participating Primary Care Physician (PCP), and with proper referrals, the right to a participating specialist.
- 5. You have the right to privacy and confidentiality with regard to your personal information.
- 6. You have the right to full disclosure from your health care provider of any information relating to your medical condition or treatment plan and the ability to examine and offer corrections to your own medical records.
- 7. You have the right to be informed of plan policies and any charges for which you will be responsible.
- 8. You have the right to a description of the procedures for obtaining out-of-area services.
- 9. You have the right to a description of the method by which you can obtain access to a summary of the plan's accreditation report.
- 10. You have the right to have medical advice or options communicated to you without any limitations or restrictions being placed upon the provider or PCP by the HMO.
- 11. You have the right to have all coverage denials reviewed by appropriate medical professionals consistent with the HMO's review procedure.
- 12. You have the right to have coverage denials involving medical necessity or experimental treatment reviewed, after exhaustion of the HMO's internal grievance procedure, by appropriate medical professionals who are knowledgeable about the recommended or requested health care service, as part of an external review.

- 13. You have the right to emergency services without prior authorization if a prudent lay person acting reasonably would have believed that an emergency medical condition existed, and the right to a description of procedures to obtain emergency services.
- 14. A woman has the right to direct access, annually, to her OB/GYN for the purpose of a well woman examination without a referral from her PCP, and no woman shall be required to obtain a referral from her PCP as a condition to coverage of prenatal or obstetrical care.
- 15. A woman whose plan provides coverage for surgical services in an inpatient or outpatient setting has the right to reconstruction of the breast following mastectomy and reconstructive or cosmetic surgery required as a result of an injury caused by the act of a person convicted of a crime involving family violence.
- 16. A woman whose plan provides coverage for laboratory or X-ray services has a right to the following when performed for cancer screening or diagnostic purposes: (1) a baseline mammogram for women age thirty-five to thirty-nine, inclusive; (2) a mammogram for women age forty to forty-nine, inclusive, at least every two years; (3) a mammogram every year for women age fifty and over; (4) a pap smear at least annually for women age 18 and over.
- 17. A nonsymptomatic person over 50 years of age and a symptomatic person under 50 years of age has the right to colorectal cancer examinations and laboratory tests for colorectal cancer.
- 18. You have the right to rehabilitation services.
- 19. You have the right to child immunization services, which shall not be subject to payment of any deductible, per-visit charge and/or copayment.
- 20. A diabetic whose health benefits policy includes eye care benefits, has the right to direct access to an optometrist or ophthalmologist of their choice from the panel without referral from their PCP for an annual diabetic retinal examination. When the diabetic retinal examination reveals the beginning stages of an abnormal condition, access to future examinations shall be subject to prior authorization from a primary care physician.